CG

Coral Gables Vestibular Clinic

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VertigoDx

FDA CLEARED · K260566

CLASS II

VESTIBULAR ASSESSMENT

HORIZONTAL-CANAL BPPV ASSESSMENT

Visit **06 Sept 2026 · 07:23**
Report no. **VDX-2026-00004**
Template: Horizontal-canal BPPV assessment

PATIENT

Margaret Ellison

DOB **14 Mar 1961**
Sex **F**
File no. **CGV-04471**
Referred by **Alan Reyes, MD (primary care)**

CLINICIAN

Sarah Whitfield, PT, DPT

Profession **Physical Therapist (PT, DPT)**
Reg. no. **FL PT 30412**
Device **SmartVertigo · iPhone 14 Pro Max**
Classifier **V4 (v24)**

HISTORY

- Onset: two weeks previously, on a Sunday, on turning over in bed to the right.
- Course: recurrent, most mornings since.
- Triggers: turning in bed, looking up to a high shelf, bending forward.
- Spell duration: less than a minute; husband estimated about 30 seconds for the first attack.
- Nausea: present, especially in the mornings. Vomiting: denied.
- Between spells: unsteadiness, no spinning unless the head is moved.
- Hearing change, tinnitus, aural fullness: denied.
- Headache: denied. Migraine in her thirties, none for twenty years.
- Double vision, speech disturbance, facial or limb numbness or weakness: denied.
- Falls: none, though near-falls reported.
- Previous episodes: none.
- Head trauma, recent viral illness: denied.
- Medication: amlodipine 5 mg, vitamin D. Vestibular suppressant: a single dose of Stugeron given by her daughter on day two, discontinued because of sedation.
- Swallowing, ataxia, prolonged bed rest, stroke risk: not documented.

Patient: "Two weeks ago on the Sunday. I turned over in bed towards the window, my right side, and the whole room went round. I grabbed the headboard." The vertigo was described as rotatory: Patient: "Spinning. Proper spinning, like a merry-go-round." Between attacks she reported: "A bit off balance. Like I am walking on a boat. But no spinning unless I move my head." Symptoms were mostly right-sided, occasionally left and much milder. Her mother had dizzy spells in her seventies, of unknown cause. On TiTrATE framing the presentation is triggered-episodic, consistent with BPPV. Red flags: unilateral hearing loss or tinnitus — explicitly denied; new severe headache — explicitly denied; focal or cerebellar symptoms (diplopia, speech, weakness, numbness) — explicitly denied; continuous non-positional vertigo — not present, symptoms positional; vertical or atypical nystagmus — see examination; high stroke risk — not documented.

EXAMINATION · 7 POSITIONS

POSITION	EYE	NYSTAGMUS	SPV	LATENCY	DURATION	CLINICIAN
Sitting	R	Down-beating 2nd opinion: No BPPV	13.7°/s	0 s	7 s	—
Lying	L	Down-beating	3.3°/s	0 s	9 s	—

POSITION	EYE	NYSTAGMUS	SPV	LATENCY	DURATION	CLINICIAN
Roll Left	L	Right-beating horizontal 2nd opinion: No BPPV	5.1°/s	0 s	2 s	—
Roll Right	R	Left-beating horizontal	4.2°/s	0 s	16 s	—
Dix-Hallpike Left	L	Down-beating 2nd opinion: No BPPV	20.4°/s	0 s	5 s	—
Dix-Hallpike Right	R	Down-beating	26.5°/s	1 s	12 s	—
Straight Head Hang	R	Up-torsional, counter-clockwise	12.6°/s	1 s	14 s	—

Dix-Hallpike Right: Dr Whitfield described a delay before onset and a strong response — Clinician: "That is a strong down-beating nystagmus, and I can see the eye rolling as well." The patient reported vertigo and transient nausea.

Straight Head Hang: Clinician: "There is an up-beating and twisting nystagmus there, counter-clockwise." The patient reported dizziness, less severe than the right Dix-Hallpike.

Roll Right: the patient reported reproduction of her vertigo — Patient: "Oh. Oh, that is it. That is the spinning." The clinician noted side-to-side beating that settled quickly.

Dix-Hallpike Left: a small down-beating nystagmus with little subjective vertigo.

ROLL-TEST ANALYSIS

Device: Roll Left — right-beating horizontal (R HN 67%), peak SPV 5.1°/s, duration 2 s. Device: Roll Right — left-beating horizontal (L HN 92%), peak SPV 4.2°/s, duration 16 s. The pattern is apogeotropic (each side beating towards the uppermost ear), right 4.2°/s versus left 5.1°/s → weaker side right. Bow-and-lean testing: not documented. The clinician did not attribute the roll findings to a horizontal canal, stating only that the right roll response arose from the same right ear.

IMPRESSION

Canal: right anterior and right posterior. Side: right. Variant: not documented. Red flags: none elicited on history; nystagmus findings attributed by the clinician to peripheral BPPV.

Dr Whitfield's view was that all findings arose from the right ear. He explained that the right Dix-Hallpike produced a clear burst of nystagmus with a delay before onset, which he attributed to the right posterior canal, and that the smaller up-beating torsional nystagmus on Straight Head Hang pointed to the right anterior canal. The left Dix-Hallpike showed only a little, and the right roll test provoked spinning from the same right ear. Clinician: "It happens. The crystals can sit in two canals on the same side." Differential considered: not documented beyond the exclusion of central features on history.

TREATMENT

Right Yacovino manoeuvre · right · one cycle · guided. Right Epley manoeuvre · right · one cycle · guided. Both tolerated.

The Yacovino manoeuvre was performed first for the anterior canal: head hanging back for thirty seconds, then chin brought quickly to the chest and held for a further thirty seconds, then sitting with the chin down. The patient reported brief spinning in the head-hanging position and afterwards: "Woozy. But the room is not going round." The Epley was then performed for the right posterior canal: head turned right and lowered over the edge, where the patient reported spinning and the clinician noted nystagmus already less than on testing; head turned ninety degrees to the left; roll onto the left shoulder looking at the floor, where the patient reported "A little swirl. Not much."; then sitting up slowly with the chin down. Nausea after treatment: not documented. Vomiting: not documented. Immediate retest of the right Dix-Hallpike showed no nystagmus and no vertigo — Clinician: "No nystagmus, and are you spinning?" Patient: "No. Just nervous."

PLAN

Review Review 7 d — review in one week to re-check the right side.

Advice Advice — no postural restrictions; the patient may lie flat and sleep on either side. Clinician: "Sleeping upright and avoiding movement does not help and just makes you stiff." The clinician stated that sleeping sitting up is old advice and the studies show it makes no difference.

Advice Advice — a floaty feeling may persist for a day or two and is expected.

Review Advice — if the vertigo returns in the next few days, telephone the practice for a repeat manoeuvre without waiting for the appointment.

Medication — no vestibular suppressants; the clinician stated they mask symptoms and delay central compensation. Continue the blood pressure tablet as usual.

Refer Refer if — severe new headache, double vision, slurred speech, weakness or numbness, or dizziness that is constant rather than in short spells: attend the emergency department immediately.

Advice Advice — remain in the waiting room for ten minutes before driving; if not steady, arrange a lift.

Advice Advice — a written summary of the findings and plan to be sent to the patient's phone.

CODING

ICD-10 H81.11 (right) benign paroxysmal vertigo; CPT 95992 canalith repositioning procedure (from the recorded treatment)

DATA NOTES

Data note: handset item "Right Roll: Ageo HN" vs classifier "Roll Right: L HN 92%".

Data note: handset item "Right Dix Hallpike latency 16-30s" vs classifier "Dix-Hallpike Right latency 1 s".

Data note: handset item "Straight Head Hang latency 2-15s" vs classifier "Straight Head Hang latency 1 s".

Data note: handset recorded Sitting as tested and clear vs classifier "Sitting: DBN 38%, peak SPV 13.7°/s"; handset recorded Supine (Lying) as clear vs classifier "Lying: DBN 67%, peak SPV 3.3°/s"; handset recorded Left Roll as clear vs classifier "Roll Left: R HN 67%, peak SPV 5.1°/s".

Data note: handset date of service recorded as 01 Jul 2026, recording date 06 Sep 2026.

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Signed electronically · 06 Sept 2026 · 07:23

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